TRIPLETS - A Rare Case Report

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Introduction

The term "Triplets" is used when three babies are born to a mother at one time. Twin deliveries are quite common but triplets are rare. Amongst multiple pregnancies, estimated incidence of twins is 1 o 86, triplets 1 of 86² and quadruplets 1 of 86³ and so on, which is called Helin's law. [1]. Incidence of multiple gestations has increased in recent past due to frequent use of ovarian stimulant drugs such as clomiphene and gonadotropins for treatment of infertility. Clomiphene increases the occurrence of dizygotic pregnancies by 5 to 10% [1,2]. Perinatal mortality rate for twins and triplets is as high as 4 to 11 times that of singleton [3]. One such case is reported here and related problems discussed.

Case Report

Triplets were born to a 29 year old primigravida mother, married for past 9 years and treated for primary infertility with clomiphene in civil, where no sonography was done. She reported to the out patient department of a zonal service hospital at 34 weeks of gestation and was advised sonological work up. Ultrasonography (Fig-1) revealed three live fetuses with vertex presentation. There was no family history of twins or triplets and her ante-natal period was uneventful. She was hospitalised and all necessary arrangements were made for the delivery and management of three preterm babies. On third day of admission, she went into labour and three male babies (Fig-2), each weighing 1500 grams were delivered by emergency lower segment Caesarean section. Three resuscitation teams were kept ready to receive the babies. Babies were asphyxiated at birth and were successfully resuscitated. There was no evidence of foetofoetal or foeto-maternal transfusion and no congenital anomaly was found in them. The first of the triplet had separate placenta, whereas second and third one shared a common chorion. All of them had their own amniotic sacs. Their blood groups were B positive, same as that of their mother.

They were managed in neonatal intensive care unit (NICU) in thermo-neutral environment, using incubator and radiant heat warmer, under complete asepsis. Expressed breast milk and re-constituted powder milk were given to them through nasogastric

tube. Prophylactic dexamethasone was given to mother before delivery and to babies after birth to prevent hyaline membrane disease. The first one, who had a separate placenta, had feed intolerance and poor thermo regulation and succumbed on fourth day of life to apnoea of prematurity. The second and third of the triplets remained stable and are growing well.

Fig. 1 : Ultrasonogram of triplets

Fig. 2 : Triplet born to a primigravida

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Disussion

Management in pregnancy and labour in triplets is done on the same lines as that in twins [4]. Real time ultrasonological examination is the key diagnostic tool for confirmation of diagnosis and can be done as early as five to six weeks of gestation [5]. Simultaneous birth of three pre term babies is a challenge to medical attendants as well as to parents. Ante natal diagnosis helps in the preparedness for their successful management.

Congenital malformations are more common in triplets and twins as compared to singletons. The common congenital anomalies reported are vertebral, anorectal, tracheoesophageal, renal and cardiac defects [1,2,6]. The incidence of foeto-foetal and foeto-maternal transfusion is as common as 15 to 50%, where donor baby is born anaemic and may even require blood transfusion [2,6]. The triplets reported by us had none of these problems.

Neonatal problems related to prematurity and intra uterine growth retardation are no different in triplets from singletons of same gestation and birth weight [2]. These problems include hypothermia, hypoglycaemia hyaline membrane disease, apnoea of prematurity, feed intolerance and hyperbilirubinaemia. They should be anticipated and managed on time. In our case, first neonate had feed intolerance and apnoea of prematurity.

In multiple pregnancies, usually first delivered baby is at low risk as compared to babies delivered subsequently, probably due to higher chances of hypoxia, but in our case, first of the triplets had more problems and did not survive which is unusual. The triplets reported here had same sex, same features and same blood groups, and hence they are likely to be monozygotic, however only immunological studies can con-

firm their zygoty. Since first neonate had a separate placenta while second and third babies shared a common one, possibility of diamniotic monochorionic twins cannot be excluded. Clomiphene usually produces polyzygotic multiple pregnancies and they may not be of same sex. However, this was not found in our case. Polyhydramnios is a common problem in mothers with multiple gestations [4] but that was not found by us. There are different schools of thought regarding trial of normal delivery in such pregnancies, however interlocking of foetuses, knotting of cords, delayed delivery of second and third babies causing hypoxia may jeopardize foetal outcome and hence Caesarean delivery may be better to overcome these problems. Energetic resuscitation and neonatal care under the supervision of a neonatologist produce rewarding outcome and good prognosis in twins/triplets.

References

1. Nelson WE, Behraman RE, Kliegman RM and Arvin AM. Multiple pregnancies in Nelson text book of Paediatrics, 15th ed. Prism Books, Bangalore, 1996;453-4.
2. Pursley DM and Slark AR. Multiple gestation. In Manual of Neonatal care, 3rd ed. Little Brown and Company, London, 1991;104-8.
3. Benson RC Multiple pregnancy. In Current Obstetric and Gynaecologic Diagnosis and Treatment. 4th ed. Lange Medical Publications, California 1982;755-63.
4. Dawn CS. High Risk Pregnancies In : Text book of Obstetrics and Neonatology. 10th ed. Dawn Books, Calcutta 1987;407-9.
5. Sanders RC. Obstetric Sinology. In Clinical Sonography- A Practical guide, 2nd ed, Little Brown and Company, Boston, 1991;124-6.
6. Meharban Singh. Haematological problems. In : Care of New born, 4th ed. Sagar publications, New Delhi, 1991;335-6.